

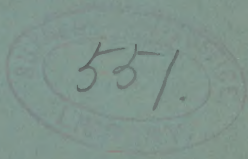
JANVRIN (J.E.)

A PLEA
FOR
EXPLORATORY ABDOMINAL SECTION
IN THE
EARLY STAGES OF TUBAL PREGNANCY.

BY
J. E. JANVRIN, M.D.,
New York.

[Reprinted from the AMERICAN JOURNAL OF OBSTETRICS AND DISEASES
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A PLEA FOR EXPLORATORY ABDOMINAL SECTION

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BEFORE entering upon what I consider the train of symptoms which call for an exploratory laparotomy in cases of suspected tubal pregnancy, it seems to me proper to refer to certain articles, by the author of this paper, upon this subject which have been published during the past five years.

1st. In the eleventh volume of the Transactions of the American Gynecological Society (1886) is the report of a case of tubal pregnancy, the details of which are well known to the members of this Society.

In summing up my conclusions as derived from this case, and all others which I was able to gather at that date, the following statement was made :

“I would submit the following as embodying my own ideas as to the proper treatment to be resorted to in certain cases of undoubted tubal pregnancy: that in cases where a moderate hemorrhage has been positively diagnosed (whether from a rupture of a superficial artery or venous plexus, or from a partial rupture of the sac itself), and this hemorrhage

¹ Read before the New York Obstetrical Society, April 21st, 1891.

has occurred prior to the termination of the fourth month of gestation, it is undoubtedly better surgery to perform laparotomy at once, and thus remove all possible danger of further hemorrhage, than to trust to electricity in any form.

"Cases of this kind, in which a positive diagnosis can be made, have been rare up to the present time, principally, I think, from the fact that the full significance of the so-called 'colicky pains,' with the shock and collapse, has hardly been appreciated. I am convinced that in these attacks there is always some bleeding, it may be very slight, from the superficial vessels of the sac; and that, as a rule, several (three or four) attacks occur before the real rupture of the sac takes place."

In a paper which I read before the New York County Medical Association on April 16th, 1888 (and published in the *New York Medical Journal*, April 28th, 1888), "On the primary removal, by abdominal section, of the tube and its contained fetus, in cases in which pregnancy has been diagnosed before rupture of any portion of the tube has occurred," the following occurs: "At a meeting of the New York Obstetrical Society held December 7th, 1886, in referring to a case in which he had diagnosed tubal pregnancy at the fifth week, Dr. Janvrin said: I infer from this case (and three others similar) that in all cases of tubal pregnancy where transient collapse symptoms suddenly appeared from the fifth to the seventh week of gestation, or even a little later, there was a rupture of one of the superficial vessels of the sac; but the final catastrophe, severe hemorrhage, did not occur until later. The time to operate was when this preliminary or partial rupture occurred. Indeed, the primary collapse symptoms constituted an almost certain indication both of the pathological condition and of the need of immediate interference.

"In his opinion the history of the patient, the presence of a rapidly growing tumor at one side of the uterus, the presence of an irregular decidual discharge in a woman who had missed a period, associated with the normal signs of pregnancy and subsequent symptoms of shock and colicky pains, could hardly be referred to any other condition, even as early as the fifth week."

Up to that date, April, 1888, I had *seen* two specimens besides my own in which this very condition was demonstrated at the autopsy. These two cases, together with the two others reported in my paper read before the American Gynecological Association in September, 1886, made five cases in which this condition had been absolutely proven at the autopsy. I consider that these five cases are sufficient to establish a principle, and that the statements made by me, nearly five years since, as to this pathological condition have been fully proven by these cases.

In addition to these cases I would refer to cases in which the secondary operation has been performed (when the tube has fully ruptured), cases reported by Johnstone, Kletsch, Tuttle, and others, in which consecutive layers of blood clots have been found, indicating different dates of extravasation, and going to show that there had been slight or moderate hemorrhage from the peritoneal surfaces of the tube before the *final* and severe hemorrhage took place.

At the March 20th, 1888, meeting of the New York Obstetrical Society, the subject of tubal pregnancy being under discussion, I said: "As for myself, in every case where I felt sure that there existed a tubal pregnancy, anywhere from the sixth to the tenth week, even in the absence of positive evidence of hemorrhage, but in the presence of the other symptoms, I would certainly resort to laparotomy rather than use electricity in any form."

One more quotation from the Transactions of the New York Obstetrical Society: At its meeting of April 3d, 1888, "Dr. Janvrin said that, in reference to tubal pregnancy, he had for some years taken the same stand that Dr. Tuttle now takes. He fully believed that this case of Dr. Tuttle's commenced as a tubal pregnancy; the attacks of peritonitis, brought on by slight bleeding from the distended tube, with the other symptoms, made it clear that it was a tubal pregnancy, and he would have expected to find it such.

"In all these cases, from the sixth to the twelfth week of gestation, the pretty severe attacks of colicky pains, with the other general symptoms, should lead us all to diagnosticate the condition; and when we are fully convinced that there is tubal pregnancy, even if there has been no decided hem-

orrhage and the patient's life is in no immediate danger, it is best to perform laparotomy. He did not believe in electricity at that time." I wish to state here that by the term "general symptoms" I do not, and never did, intend to be understood (as I have been charged) to mean the rational symptoms. If I had wanted to say rational, I should have done so at the time. The word, I believe, as given by our best authorities, means "having a relation to all; common to the whole; universal, etc.," and must therefore take into account *all* the symptoms in any given case or class of cases.

In the cases which have come under my observation, and which have been recognized early, the following train of symptoms has invariably been met with:

First, the passing one period, followed, usually within two weeks, by a slight bloody discharge, while at the same time the usual symptoms of pregnancy exist.

Second, the examination of the expelled fluid will generally show the presence of decidual membrane.

Third, by physical examination we find the os uteri slightly patulous, the uterus slightly enlarged and somewhat heavier than normal, and tipped to either the right or left of the median line, the deviation being away from the enlarged tube. The uterus is also flattened antero-posteriorly, and the cornua projecting toward either side. The mass itself is slightly elastic, slightly movable, *very sensitive to the touch*, and usually about the size of a pullet's egg. There is also generally a strong arterial pulsation in the mass.

These symptoms certainly indicate the presence of a growth *outside* of the uterine cavity, with a fair probability that it is a pregnant tube; and under such circumstances it is certainly justifiable to explore the uterus with the sound. When this is done the depth of the uterus will rarely be found to exceed three inches, even up to the seventh or eighth week of gestation. Watching the case carefully for a few days even, we can easily notice the *very rapid growth of the tumor*, and the non-increase in the size of the uterus. It is during this period, from the fifth to the seventh week of gestation, as a rule, that we get the slight attacks of pain, accompanied by more or less shock, which I have attributed

to the tearing of the peritoneal covering of the sac and the laceration of the nerve filaments therein; and this of course is, as stated before, accompanied by slight bleeding.

With such symptoms existing, it is the duty of every good abdominal surgeon to perform abdominal section. The condition is one which is becoming more serious every moment, and one which may at any moment result in a terrific hemorrhage into the peritoneal cavity and put an end to the patient's life at once.

It is not, in my opinion, justifiable to lose time, and probably the patient's life, by playing with electricity.

The condition is tenfold more serious and critical than that existing in the ordinary cases of pyo-salpinx or ovarian tumors; and while there is a possibility that we may be mistaken in our diagnosis, still there is an almost absolute certainty that we shall find, if not a tubal pregnancy, some growth which, according to the most advanced rules of abdominal surgery, should be treated surgically and not empirically—should be removed, and not left to kill the patient or to cause a long-continued state of invalidism.

As will be seen, all of the foregoing, in substance, I published in the different papers alluded to between September, 1886, and September, 1888. Since that time a good deal has been written by others, and quite a good deal has been done in the way of operations, bearing upon this subject.

It is my purpose to confine myself in this short paper to those points which bear upon the very early diagnosis of tubal pregnancy; and the remainder of this paper will be devoted to a few salient points gleaned from the observations and experiences of others who have been particularly interested in this matter.

J. Bland Sutton, in the "Erasmus Wilson Lecture," February, 1891, "On Some Points on the Pathology of Tubal Pregnancy," says: "Salpingitis so severe as to produce destruction of the total epithelium causes such profound changes in the tubes themselves as to lead to stricture and occlusion of the abdominal ostia; it is exceedingly rare to meet with tubes denuded of their epithelium and the abdominal ostia patent." . . . "In several specimens of very early tubal pregnancy I have failed, even after the most care-

ful microscopic examination, to find any evidence of old salpingitis or loss of epithelium." He further states that "during the fourth to the twelfth week of gestation the increase in size in the gravid tube is simply a turgescence, and not an increase in size and number of the muscle cells as in the gravid uterus."

By the end of the sixth week, or at the eighth at the latest, the swollen margin of the peritoneum "projects over the fimbriæ and contracts and hermetically closes the ostium."

He further gives his ideas as to the pathological changes which so often occur in the ovum, resulting in the formation of "blighted ovum," "apoplectic ovum," etc., in the uterus, and states, "it would appear that an apoplectic ovum *in the tube* is a frequent means of inducing tubal abortion or rupture," and that "tubal abortion can only occur during the *first month*, when the ovum is small enough to pass through the abdominal ostium." With excessively rare exceptions, a pregnant tube "either ruptures or aborts at some period before the twelfth week following impregnation."

These conclusions are based upon very careful observations, and to me seem true as a whole. At the same time the specimen presented before this Society just one month since by Dr. Tuttle shows that tubal abortion *may* occur as late as the second month of gestation. If in nearly every case of tubal abortion the accident must "occur during the first month," we are forced to the conclusion that this method of extrusion of the fetus from the tube is after all very rare; and we are compelled to accept as a fact that laceration, or partial laceration, of the tube is by far the more frequent accident.

In either case the same train of symptoms practically obtains from the time of conception up to the beginning of the extrusion of the fetus through the ostium or up to the beginning of the tearing of the tube by over-distention. In the one case there is slight hemorrhage *from the mouth* of the tube, in the other from a tear in the *peritoneal covering*. This slight hemorrhage accounts for the first few attacks of pain and shock and slight collapse, the other symptoms in all cases being, as I believe, identical, and as have already been described.

It seems to me that, with these symptoms, indicating, as I

believe, a threatening of a most formidable, and too often fatal, accident to the patient, it is criminal negligence for any good abdominal surgeon to defer abdominal section. It is even more criminal to make use of galvanism or faradization in these cases of impending hemorrhage.

Even if the fetus is destroyed, the mass remains in the tube and renders that tube and ovary practically functionless, even if it should not ever give any serious trouble in after-life. Such trouble, however, has been witnessed repeatedly. The fetus has ulcerated its way out. Dr. Mann has reported two cases. In both of Dr. Allen's cases serious inflammatory trouble followed for a long time. Dr. Harris has also collected the history of quite a large number of cases in which serious and long-continued trouble has followed upon the killing of the fetus by electricity. With the perfectly satisfactory results which have attended the few cases already reported as operated upon by abdominal section before rupture of the sac, and the good results which have also attended the secondary operation (after the sac has really ruptured), we have every inducement and every reason, I think, to urge us to the performance of this operation *as soon as we are convinced of the presence of a fetus in the tube*, and before rupture of the tube has occurred.

It is the *ideal* operation for all such cases, and at the same time one which will constantly increase in numbers and prove one of the greatest boons to the human race.



